

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02352

2342

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i></i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Rosa</i>	Middle <i>L</i>	Last <i>adams</i>
4. DATE OF DEATH <i>Jul. 14 1957</i>	Month <i>Jul.</i>	Day <i>14</i>	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 31-1877</i>
9. AGE (In years, months, birthday) <i>79/10/13</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	11. BIRTHPLACE (State or foreign country) <i>Concordville, Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>Eliza Jane Bradford</i>
13. FATHER'S NAME <i>James Cooper</i>	14. MOTHER'S MAIDEN NAME <i>Eliza Jane Bradford</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>26-09-6129</i>	17. INFORMANT <i>Mrs. Rosalie Hollings, Snow Hill, Md</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b) <i>Hypertension, Cerebral vascular Disease</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>700</i>
20f. (City or town) <i></i>		(County) <i></i> (State) <i></i>	
21. I certify that I attended the deceased from <i>5/10</i> , 19 <i>56</i> , to <i>2/14</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>2/14</i> , 19 <i>57</i> , and that death occurred at <i>700</i> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <i>Thomas L. Jones, M.D. 312 E. Market St, Snow Hill, Md. 21557</i>			
DATE SIGNED <i>2/15/57</i>			
ACTUAL SIGNATURE <i>Thomas L. Jones, M.D.</i>		PHYSICIAN'S NAME (Type) <i>Thomas L. Jones, M.D.</i>	
22. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 1/16/57</i>		22b. DATE THEREOF <i>1/16/57</i>	
22c. NAME OF CEMETERY OR Crematory <i>Whitewell Cemetery</i>		22d. LOCATION (City, town, or county) <i>Snow Hill</i>	
(State) <i>MD</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>May & Dennis, Snow Hill, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 19 1957</i>	
ADDRESS <i>May & Dennis, Snow Hill, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Elwyn Cooper</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V.

FEB 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2343

CERTIFICATE OF DEATH

102353
305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) to Berlin (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1 Route #3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Cora	Middle E.	Last Birmingham
4. DATE OF DEATH	Month 2	Day 25	Year 1957
5. SEX F.m.	6. COLOR OR RACE A.A.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-1915
9. AGE (In years less birthday) 41	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work	11. KIND OF BUSINESS OR INDUSTRY Home	12. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME George Jerry	14. MOTHER'S MAIDEN NAME Sally V. Heath	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) None	
16. SOCIAL SECURITY NO. 215-26-5292		17. INFORMANT Charles Birmingham, Berlin, Md. R#3	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X		INTERVAL BETWEEN ONSET AND DEATH 16 hrs	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Essential hypertension 1 1/2 yrs	
DUE TO Diabetes mellitus (c)		1 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 4201		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/16 , 1955, to 1/22 , 1957, that I last saw the deceased alive on 1/22 , 1957, and that death occurred at 2:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Ivory V. Sully M.D. DATE SIGNED 2/25/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-1-1957	22c. NAME OF CEMETERY OR CREMATORIAL African Baptist Cemetery
22d. LOCATION (City, town, or county) Cheriton, Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home		24a. ADDRESS Salisbury, Md.	24b. REC'D BY REGISTRAR DATE MAR 5 1957
		24b. REGISTRAR'S SIGNATURE Helen F. Haywards	

21. STATEMENT OF HIGH-LEVEL STATEMENT

CHIEFAGE OF CATH

BUREAU

MAR 4

REGEL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film 210 2-14-57 et

2340

CERTIFICATE OF DEATH

112354

Reg. Dist. No.

350

1. PLACE OF DEATH
a. COUNTY

Worcester

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE
Maryland

b. COUNTY
Worcester

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Pocomoke City,

42 Pocomoke City,

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Home

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

Annie

Ginn

Collins

First Middle Last

4. DATE
OF
DEATH

February 2

1957

5. SEX

F.

6. COLOR OR RACE

C.

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

May 14, 1894

9. AGE (In years
lost birthday)

62

yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joshua Purnell

14. MOTHER'S MAIDEN NAME

Hattie Mary Pitts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Sarah Marshall

Address

Stockton, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

002X

DUE TO

Tuberculosis of the Lungs

INTERVAL BETWEEN
ONSET AND DEATH

D.K.

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

DUE TO

(b)

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.

20d. INJURY OCCURRED
While at work Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Jan. 1957, to Feb. 1st. 1957, that I last saw the deceased
alive on Feb. 1st. 1957, and that death occurred at 6 p. m., from the causes and on the date stated above.

ADDRESS (Street, City or Town, State)

DATE SIGNED

ACTUAL
SIGNATURE

N. B. Bartories M.D. Pocomoke City, Md. 2-3-57

PHYSICIAN'S
NAME (Type)

N. E. Sartorius

22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

2/4/57

22b. DATE THEREOF
Georgetown Cem.

22d. LOCATION (City, town, or county)

(State)

Pocomoke City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Edgar Wharton New Church, Va. 2/6/57 Anne E. White

RECEIVED
FEB 8 1957

BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02355

2344

CERTIFICATE OF DEATH

Reg. Dist. No. 358-

1. PLACE OF DEATH a. COUNTY WORCESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD		b. COUNTY WORCESTER		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b 14 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 BERLIN		d. STREET ADDRESS 13 BROAD ST		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ELLA TOWNSEND CROPPER		First	Middle	Last	4. DATE OF DEATH FEB 23 1957	Month	Day	Year
5. SEX F	6. COLOR OR RACE WV	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 10, 1870		9. AGE (In years last birthday) 87 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) BERLIN MD. P.F.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOSIAH TOWNSEND		14. MOTHER'S MAIDEN NAME LETITIA VAN DOGH.						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT MR. SIDNEY CROPPER NEWARIS MD.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Acute Dilated Heart		DUE TO Chronic Hypertension & arteriosclerosis		DUE TO Age.		INTERVAL BETWEEN ONSET AND DEATH 7 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Berlin		20f. (City or town) Berlin		(County) MD (State) MD
21. I certify that I attended the deceased from Dec 1 1956 to Feb 23 1957 that I last saw the deceased alive on Feb 23 1957 , and that death occurred at 4:40 AM , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Berlin DATE SIGNED Feb 23 1957								
ACTUAL SIGNATURE Chas. R. Low		PHYSICIAN'S NAME (Type) M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/25/57		22c. NAME OF CEMETERY OR CREMATORIUM GARDEN OF MEMORIES		22d. LOCATION (City, town, or county) NEWARIS (State) MD		
23. FUNERAL DIRECTOR'S SIGNATURE Anna R. Burbage		ADDRESS Berlin MD.		24a. REC'D BY REGISTRAR 2/25/57		24b. REGISTRAR'S SIGNATURE Stelen + Stayward		

RECEIVED - CIVILIAN DEFENSE - WASH. D. C.

BUREAU V. 4

FEB 26 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be joined by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1-2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02356
355

2345

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY WORCESTER									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin (RURAL)		c. LENGTH OF STAY IN 1b All her life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		d. STREET ADDRESS Route # 2									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) MARGARET		First Ellen	Middle Cutler	Last Cutler	4. DATE OF DEATH 2 22 1957	Month 2	Day 22	Year 1957							
5. SEX F.M.	6. COLOR OR RACE A.A.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-21-1888	9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months —	IF UNDER 24 HRS. Days —	Hours —	Min. —							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORKS		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.									
13. FATHER'S NAME George R. Hammond		14. MOTHER'S MAIDEN NAME MARGARET Selby		Address											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 332X		16. SOCIAL SECURITY NO. 216-09-5895		17. INFORMANT Mrs. Pauline C. Parnell											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Cerebral Thrombosis (b) DUE TO (c) Essential hypertension						INTERVAL BETWEEN ONSET AND DEATH 5 days									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 260X Diabetes mellitus						23									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1		20f. (City or town) Berlin		(County) Md.		(State) Md.	
21. I certify that I attended the deceased from 5/4 1956 to 2/21 1957 , that I last saw the deceased alive on 2/21 1957 , and that death occurred at 12:45 AM , from the causes and on the date stated above.															
ACTUAL SIGNATURE Frances M. Shulley, M.D.		ADDRESS Berlin, Md.		ADDRESS (Street, city or town, state) Berlin, Md.		DATE SIGNED 2/23/57									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-57		22c. NAME OF CEMETERY OR CREMATORIUM Family Cemetery		22d. LOCATION (City, town, or county) Berlin 1st & 2nd Sts., Md.									
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.		ADDRESS J. F. Stewart Funeral Home, Salisbury, Md.		24d. REC'D BY REGISTRAR DATE MRB 3 1957		24b. REGISTRAR'S SIGNATURE Robert J. Raymond									

RECEIVED
BUREAU V. S.

MAR 4 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02357
356

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

2345

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM43. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY WORCESTER		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN R.F.D.	
3. NAME OF DECEASED (Type or print) CHARLES H. DENNIS		d. STREET ADDRESS CHANGYTOWN	
4. DATE OF DEATH FEB 16 1957		Month	Day
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 8 1893
9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABURER		10b. KIND OF BUSINESS OR INDUSTRY CHICKEN PLANT	
11. BIRTHPLACE (State or foreign country) PITTLADGE, PA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN DENNIS		14. MOTHER'S MAIDEN NAME MARY BROOKMAR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-26-3542	
17. INFORMANT Mrs. IVAN DENNIS (HINCHINBROOK)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture (Cervical spine) - Fracture to 7-8-9-10 Rib Left Cont. & Comp. of Chest.			
DUE TO (c) 7-8-9-10 Rib Left Cont. & Comp. of Chest.			
INTERVAL BETWEEN ONSET AND DEATH Instant			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Head on collision, off Rd 52, Compaction Rd, Worcester Co.	
20c. TIME OF INJURY 6:05 a.m. Feb 16 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg, etc) off Rd 52, Worcester Co.
		20f. (City or town) ST MARTINS, Worcester Co., Md	(County) WORCESTER (State) MARYLAND
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Terrian A. Robbins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Terrian A. Robbins M.D.		DATE SIGNED 2/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/19/57	22c. NAME OF CEMETERY OR CREMATORIAL TAYLORVILLE
22d. LOCATION (City, town, or county) BERLIN (R.F.D. MD)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burley Berlin Md		24a. REC'D BY REGISTRAR DATE 2/19/57	24b. REGISTRAR'S SIGNATURE Helen F. Haywards

REGISTRATION
NUMBER

FEB 20 1957

RECEIVED
FEB 20 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG211 2-25-5 a

02358

Reg. Dist. No. 55

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be signed by the hospital or attending physician.

DOCTOR OF FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and ~~immediately filed~~, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Worcester				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Stockton		d. STREET ADDRESS 1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Hattie		First E. Middle Foreman		4. DATE OF DEATH February 4		Month 19	Day 57	
5. SEX F.	6. COLOR OR RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 15 1899	9. AGE (In years last birthday) 58	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY House wife		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Saunders Horsey				14. MOTHER'S MAIDEN NAME Lovio Brittingham				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Stockton, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 2								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1/22/52 , to 2/4/52 , that I last saw the deceased alive on 2/4/52 , and that death occurred at 545 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) Thomas L. Jones, M.D. Stockton, Md. 2/8/52 DATE SIGNED Thomas L. Jones, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/8/57		22c. NAME OF CEMETERY OR CREMATORIUM Foreman Cemetery		22d. LOCATION (City, town, or county) (State) Stockton, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Overholt				ADDRESS New Church, Va.		24a. REC'D. BY REGISTRAR DATE 2/9/57		
						24b. REGISTRAR'S SIGNATURE Elroy E. Cooper		

BUENO V. S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
23 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02359
No. 35

Reg. Dist. No.

351

DO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

DO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. LENGTH OF STAY IN 1b <i>30 yrs</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS " "				
3. NAME OF DECEASED (Type or print) <i>John Gillett</i>		4. DATE OF DEATH Month <i>Jul.</i> Day <i>22</i> Year <i>1957</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Last <i>March 27-1904</i> 53 yrs 25 days	9. AGE (In years last birthday) Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Timber Woods</i>	11. BIRTHPLACE (State or foreign country) <i>New Church, Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Edward Gillett</i>	14. MOTHER'S MAIDEN NAME <i>Matilda Spencer</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				
16. SOCIETY MEMBERSHIP (If yes, give war or dates of service) <i>None</i>	17. INFORMANT <i>Spouse</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>929.9</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>None</i> DUE TO (c) <i>(?) accidental or homicide</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a) 20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <i>0. m.</i> <i>19</i>	Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Ware</i>	(County) <i>Ware</i>	(State) <i>Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> ACTUAL SIGNATURE <i>N.E. Sartoris</i> EXAMINER'S NAME (Type) <i>N.E. Sartoris</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Feb 27 1957</i>	22c. NAME OF CEMETERY OR CREMATORIY <i>St James Cemetery</i>	22d. LOCATION (City, town, or county) <i>Snow Hill</i>	(State) <i>Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mayo Dennis</i>	ADDRESS <i>Snow Hill, MD</i>	24a. REC'D BY REGISTRAR DATE <i>Feb 27 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Charles C. Cason</i>			

BUREAU V.

FEB 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2349

CERTIFICATE OF DEATH

02369
253

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Worcester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop		c. LENGTH OF STAY IN 1b 30 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Taishah		First	Middle	Last	4. DATE OF DEATH 3 Feb.	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1908	9. AGE (In years last birthday) 48 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacconist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Isaac Parker				14. MOTHER'S MAIDEN NAME Martha Harmon				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. 217-01-1351		17. INFORMANT Ella Purnell, Bishop, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 weeks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 430.1						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1326 1/2 St. Bishop, Md.		20f. (City or town) Bishop, Md.	(County) Worcester Co.	(State) Md.
21. I certify that I attended the deceased from Jan 14 - 1957 to Feb 3 - 1957 that I last saw the deceased alive on Feb 1 - 1957 and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1326 1/2 St. Bishop, Md. DATE SIGNED 3-4-57								
ACTUAL SIGNATURE Chas. P. Parker		NAME (Type) Chas. P. Parker		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Sarah Dukes	22d. LOCATION (City, town, or county) Bishop, Md. (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Watson		ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR 37		24b. REGISTRAR'S SIGNATURE Edgar R. Berger		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED V. 2

FEB 7 1957

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02362
350

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2341

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN lb minutes		b. COUNTY Somerset		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Pocomoke City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Market Street				d. STREET ADDRESS RED #1					
3. NAME OF DECEASED (Type or print) John		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1877		9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John H. Peacock				14. MOTHER'S MAIDEN NAME Ester Ann Ross					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT 215-14-3594 Mrs. Alice E. Peacock, Pocomoke, Md.			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Due to <i>Chronic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Exertional</i>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Exertional</i>						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> <i>N. E. Sartorius Sr.</i>									
ACTUAL SIGNATURE <i>N. E. Sartorius Sr.</i>									DATE SIGNED 2/25/57
EXAMINER'S NAME (Type) N. E. Sartorius Sr.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-1-57		22c. NAME OF CEMETERY OR CREMATORIAL Baptist Cemetery			22d. LOCATION (City, town, or county) Poocomoke City, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Watson</i>				24a. REC'D. BY REGISTRAR MAR 1 1957					
ADDRESS Pocomoke, Md.				24b. REGISTRAR'S SIGNATURE <i>June H. Hester</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU Y. S

MAR 1 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with
Page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 & 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2350

CERTIFICATE OF DEATH

02363

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY WORCESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived—If institution, Residence before admission) a. STATE Md.		b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		c. LENGTH OF STAY IN 1b 31 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill, Md x		d. STREET ADDRESS 203 Willow St			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nellie K. Richardson		First	Middle	Last	4. DATE OF DEATH Feb 27 1957	Month	Day	Year	
5. SEX F.m.	6. COLOR OR RACE A.A.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1E-2-1885	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEASONAL WORK		10b. KIND OF BUSINESS OR INDUSTRY FACTORY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Shaper Kernry		14. MOTHER'S MAIDEN NAME Amy Ewell							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 219-03-7678		17. INFORMANT Mr. Lee Richardson		Address 203 Willow St Snow Hill, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		ACUTE CORONARY OCCLUSON				INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 104 Bay St		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/22/57 , 19, to 2/27/57 , 19, that I last saw the deceased alive on 2/26/57 , 19, and that death occurred at 3:00 AM , from the causes and on the date stated above ACTUAL SIGNATURE Robert C. La Mar PHYSICIAN'S NAME (Type) ROBERT C. LA MAR, M.D.						ADDRESS (Street, city or town, state) 104 Bay St			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-3-57		22c. NAME OF CEMETERY OR CEMETORY Mt. Zion Baptist Cemetery		22d. LOCATION (City, town, or county) Snow Hill, Md			
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Stewart Funeral Home, Salisbury, Md		ADDRESS J.F. Stewart Funeral Home, Salisbury, Md		24a. REC'D BY REGISTRAR DATE 6 14 57		24b. REGISTRAR'S SIGNATURE Elmer Cooper			

BUREAU V. 2

MAR 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2351

CERTIFICATE OF DEATH

02364
251

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>Worcester</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Worrells</i>		c. LENGTH OF STAY IN 1b <i>16 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Worrells</i>		d. STREET ADDRESS <i>Worrells</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>Sarah</i>	Middle <i>S.</i>	Last <i>Shackley</i>	4. DATE OF DEATH <i>Feb. 22 1957</i>	Month <i>Feb.</i>	Day <i>22</i>	Year <i>1957</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb 1-1871</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gun Home</i>		11. BIRTHPLACE (State or foreign country) <i>Stockton, MD</i>		9. AGE (In years day birthday) <i>86 yrs</i>		
13. FATHER'S NAME <i>George Brown</i>		14. MOTHER'S MAIDEN NAME <i>Margret Holland</i>		12. CITIZEN OF WHAT COUNTRY? <i>None</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Nettie Hayden</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170X</i>		Address <i>Stockton, MD</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>Cachexia & Emaciation</i>		DUE TO (b) <i>Metastatic carcinoma of the Breast</i>		DUE TO (c) <i>1 yr.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		Month <i>Feb.</i>	Day <i>22</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/> <i>1957</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Snow Hill, Md.</i>	20f. (City or town) <i>Snow Hill, Md.</i>	(County) <i>Snow Hill, Md.</i>	(State) <i>MD</i>
21. I certify that I attended the deceased from <i>June 1, 1954</i> to <i>Feb 22, 1957</i> , that I last saw the deceased alive on <i>Feb 22, 1957</i> , and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Snow Hill, Md.</i>								
DATE SIGNED <i>2-23-57</i>								
ACTUAL SIGNATURE <i>Robert C. La Mar</i>								
PHYSICIAN'S NAME (Type) <i>Robert C. La Mar, M.D.</i>								
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial Feb 25 1957</i>		22b. NAME OF CEMETERY OR CREMATORIUM <i>Stockton</i>		22c. LOCATION (City, town, or county) <i>Stockton</i>		(State) <i>MD</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer L. Morris, Snow Hill, Md.</i>		ADDRESS <i>Snow Hill, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>Feb 25 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Elmer L. Morris</i>		

BUREAU V. S.

FCG 05 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2352

CERTIFICATE OF DEATH

02365
251

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Mercer</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. LENGTH OF STAY IN 1b <i>57 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>Albie</i>	Middle <i>La</i>	Last <i>Smack</i>	4. DATE OF DEATH <i>Feb 9 1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 6 1899</i>	9. AGE (In years, last birthday) <i>57 1/4 yrs.</i>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Our Home</i>	10c. BIRTHPLACE (State or foreign country) <i>Snow Hill, MD</i>	12. CITIZEN OF WHAT COUNTRY? <i>Housewife</i>
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13. FATHER'S NAME <i>David H. Hals</i>	14. MOTHER'S MAIDEN NAME <i>Sallie Richardson</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>217-05-7597</i>	17. INFORMANT <i>Willaunee L. Smack, Snow Hill, MD</i>		Address	
17. INFORMANT <i>Willaunee L. Smack, Snow Hill, MD</i>					
Address					

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1. 4X</i>	DUE TO <i>Cachexia & Inanition</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2 mos</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Adeno Carcinoma of Rectum</i>	DUE TO <i>(b)</i>	2 yrs
	DUE TO <i>(c)</i>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <i>January 1, 1953</i> to <i>Feb. 9, 1957</i> that I last saw the deceased alive on <i>February 8, 1957</i> , and that death occurred at <i>3:30 AM</i> , from the causes and on the date stated above.

ACTUAL SIGNATURE <i>Robert G. La Mar</i>	M.D.	ADDRESS (Street, city or town, state) <i>104 Bay St</i>
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PHYSICIAN'S NAME (Type) <i>ROBERT G. LA MAR, MD</i>	22d. LOCATION (City, town, or county) <i>Snow Hill, MD</i>	(State)
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22e. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Funeral dir 1957</i>	22f. DATE THEREOF <i>March 20, 1957</i>	22g. NAME OF CEMETERY OR CREMATORIUM <i>Methodist</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>May G. Cooper</i>	ADDRESS <i>Snow Hill, MD</i>	24a. REC'D BY REGISTRAR DATE <i>Feb 19 1957</i>	24b. REGISTRAR'S SIGNATURE <i>May G. Cooper</i>
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THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. A.

FEB 10 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2353

CERTIFICATE OF DEATH

02366

Reg. Dist. No. 351

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. LENGTH OF STAY IN 1b <i>77 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>xo Snow Hill</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Olive</i>	Middle <i>M</i>	Last <i>Sullivan</i>
4. DATE OF DEATH	Month <i>Feb.</i>	Day <i>19</i>	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 11-1879</i>
9. AGE (In years last birthday yrs.) <i>77 1/2</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Snow Hill, Md</i>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>William S. Riley</i>		14. MOTHER'S MAIDEN NAME <i>Emily Fleming</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (If yes, give war or date of service) <i>No</i>		16. INFORMANT <i>Mr. Jewell Stegg, Snow Hill, Md</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170x</i> DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i> (b) <i>Caule Coronary Occlusion</i> DUE TO <i>Carcinoma of the Breast - metastases</i> (c) <i>2 days</i>		INTERVAL BETWEEN ONSET AND DEATH <i>16 mos.</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m.	Month, Day, Year <i>1956</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) <i>104 Bay St</i> (State)
21. I certify that I attended the deceased from <i>Feb 1</i> , 1956, to <i>Feb 19</i> , 1957, that I last saw the deceased alive on <i>Feb 19</i> , 1957, and that death occurred at <i>9:00</i> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Robert C. La Mar</i> DATE SIGNED <i>2-20-57</i>			
PHYSICIAN'S NAME (Type) <i>ROBERT C. LA MAR, M.D.</i>		Snow Hill, Maryland	
22a. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) <i>Funeral 2/15/57</i>		22b. NAME OF CEMETERY OR CREMATORIAL <i>Episcopal</i>	
22c. LOCATION (City, town, or county) <i>Snow Hill, Md</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clayton Dennis</i>		24a. REC'D. BY REGISTRAR DATE <i>EB 25 1957</i>	
ADDRESS <i>Snow Hill, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Elwyn Capers</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF ALABAMA - BIRMINGHAM 37
CERTIFICATE OF DATA

BUREAU V. S.

FEB 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2354

CERTIFICATE OF DEATH

102367

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden (Rural)		c. LENGTH OF STAY IN 1b X/ Eden (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 21		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM		First Middle	Last WILSON
4. DATE OF DEATH February 10th 1957	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1879
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR 4 Months	11. IF UNDER 24 HRS. 12 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William H. Wilson	
14. MOTHER'S MAIDEN NAME Elizabeth Pusey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Elizabeth D. Wilson (Wife) R.D.# 2 Eden, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Arterio-sclerotic heart disease Years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-6 , 19 57 , to 2-10 , 19 57 , that I last saw the deceased alive on 2-6 , 19 57 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Earl L. Rover		M.D. Camden Ave. (Office) DATE SIGNED Feb. 11 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 13, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park		22d. LOCATION (City, town, or county) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		ADDRESS DATE 2/14/57	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Mary Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 2 hours after death.

RECEIVED

BUREAU V. S.

RECEIVED